(Please Insert LPHA letterhead here)
or LPHA Name
Address
City, State, Zip Code

Latent Tuberculosis Infection (LTBI) Treatment Completion

This letter is to certify that _____, _____ ,
(Patient's Full Name) (Date of Birth)

has completed a recommended regimen for LTBI: _____ for
(Medication/Dosage/Frequency)

_____ months from _____ to _____.
(#) (Month/Year) (Month/Year)

It is recommended that you be evaluated annually by a medical provider for signs and symptoms of active TB disease. If you develop any of the following signs or symptoms of active TB disease at any time seek immediate medical attention, including a posterior/anterior chest x-ray. Please wear a surgical mask to the emergency room, urgent care, or medical provider's office).

- Signs and symptoms of active TB disease:
  - ✓ Cough lasting longer than three (3) weeks and or/coughing up blood
  - ✓ Unexplained weight loss
  - ✓ Night sweats
  - ✓ Unexplained fever

_____ _____
(Signature of Medical Provider/Nurse) (Date)